		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010561

Facility Name: Knox County Nursing Home

Address: P.O. Box 219, N. Market Street (Number) Knoxville (City) 61448 (Zip Code)

County: Knox

Telephone Number: (309) 289-2338 **Fax #** (309) 289-8384

IDPA ID Number: 376001167001

Date of Initial License for Current Owners: 10/23/46

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven D. Tenhouse, Olive LLP **Telephone Number:** (217) 753-1375

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Ben Perkins

(Title) Administrator, Knox County Nursing Home

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Olive LLP

(Firm Name & Address) 205 S. 5th Street, Suite 645, Springfield, IL 62701

(Telephone) (217) 753-1375 Fax # (217) 744-0193

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,664	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,664	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	44,325	14,704	3,493	62,522	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,325	14,704	3,493	62,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.74%

D. How many bed-hold days during this year were paid by Public Aid?
679 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/28/66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,427

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	347,644	30,926		378,570	6,435	385,005		385,005			1
2	Food Purchase		283,370		283,370		283,370		283,370			2
3	Housekeeping	239,488	44,336	10,232	294,056		294,056		294,056			3
4	Laundry	210,879	30,227		241,106		241,106		241,106			4
5	Heat and Other Utilities			217,901	217,901		217,901		217,901			5
6	Maintenance	104,320	11,913	104,516	220,749		220,749		220,749			6
7	Other (specify):*											7
8	**TOTAL General Services**	902,331	400,772	332,649	1,635,752	6,435	1,642,187		1,642,187			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,583,512	335,891	386,789	3,306,192	(52,959)	3,253,233		3,253,233			10
10a	Therapy		6,533	160,544	167,077	11,406	178,483		178,483			10a
11	Activities	111,686	7,166		118,852	508	119,360		119,360			11
12	Social Services	90,850			90,850	1,445	92,295		92,295			12
13	Nurse Aide Training			6,047	6,047		6,047		6,047			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,786,048	349,590	556,980	3,692,618	(39,600)	3,653,018		3,653,018			16
	C. General Administration											
17	Administrative	63,054		5,005	68,059		68,059		68,059			17
18	Directors Fees											18
19	Professional Services			16,005	16,005		16,005		16,005			19
20	Dues, Fees, Subscriptions & Promotions			41,411	41,411		41,411	(27,777)	13,634			20
21	Clerical & General Office Expenses	179,215	24,051	20,847	224,113		224,113	34,397	258,510			21
22	Employee Benefits & Payroll Taxes			991,008	991,008		991,008		991,008			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,444	1,444		1,444		1,444			24
25	Other Admin. Staff Transportation		559		559		559		559			25
26	Insurance-Prop.Liab.Malpractice			16,700	16,700		16,700		16,700			26
27	Other (specify):*											27
28	**TOTAL General Administration**	242,269	24,610	1,092,420	1,359,299		1,359,299	6,620	1,365,919			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,930,648	774,972	1,982,049	6,687,669	(33,165)	6,654,504	6,620	6,661,124			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Knox County Nursing Home #0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			165,608	165,608		165,608	3,054	168,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			165,608	165,608		165,608	3,054	168,662			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,821		36,821	33,165	69,986		69,986			39
40	Barber and Beauty Shops	32,221	1,712		33,933		33,933		33,933			40
41	Coffee and Gift Shops		13,327		13,327		13,327		13,327			41
42	Provider Participation Fee			113,628	113,628		113,628		113,628			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	32,221	51,860	113,628	197,709	33,165	230,874		230,874			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,962,869	826,832	2,261,285	7,050,986		7,050,986	9,674	7,060,660			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,777)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	3,054			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,723)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	34,397		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 34,397		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 9,674		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program	X		33,165	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 33,165		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/1/99

Ending: 11/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vendor Income	$	1	1
2	Barber and Beauty Revenue		40	2
3	Extraordinary Income/(Expense)			3
4	(Gain)/Loss on Sale of Assets		30	4
5	Miscellaneous (Income)/Expense		21	5
6	Adjust Depreciation Expense to Schedule XI	3,054	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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15				15
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89				89
90	**Total**	3,054		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(27,777)	0	0	0	0	0	0	0	0	0	0	(27,777)	20
21	Clerical & General Office Expenses	0	34,397	0	0	0	0	0	0	0	0	0	34,397	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(27,777)	34,397	0	0	0	0	0	0	0	0	0	6,620	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,777)	34,397	0	0	0	0	0	0	0	0	0	6,620	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/1/99 **Ending:** 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,054	0	0	0	0	0	0	0	0	0	0	3,054	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,054	0	0	0	0	0	0	0	0	0	0	3,054	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,723)	34,397	0	0	0	0	0	0	0	0	0	9,674	45

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Knox County	100%	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		21	Bookkeeping and Accounting	$	Knox County	100.00%	$ 34,397	$ 34,397	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$ 34,397	$ * 34,397	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Knox County
Street Address: 200 S. Cherry Street
City / State / Zip Code: Galesburg, IL 61401
Phone Number: ((309) 345-3837
Fax Number: ((309) 343-7002

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		Bookkeeping & Payroll								2
3										3
4		County Clerk's Office:	Avg. number of checks	6,488	6488	19,633	19,633	1,605	4,857	4
5	21	Salary - clerical	processed during four							5
6			year period							6
7										7
8		County Treasurer's Office:								8
9	21	Salary - bookkeeping	Number of employees	436	436	24,611	24,611	178	10,048	9
10	21	Salary - clerical	Number of employees	436	436	47,744	47,744	178	19,492	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 91,988	$ 91,988		$ 34,397	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1				N/A			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 100,375 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	1,481,040	1966	$ 156,600	1
2					2
3	TOTALS	1,481,040		$ 156,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204		1966	1966	$ 1,842,192	$ 36,844	50	$ 36,844	$ (0)	$ 1,261,984	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1966 Land Improvements			1966	46,724	934	50	934	0	31,184	9
10	1971 Additions			1971	152,822		20			152,822	10
11	1980 Additions			1980	15,242		20			15,242	11
12	1981 Additions			1981	650	33	20	33	(1)	641	12
13	1983 Additions			1983	14,762	217	20	217		14,164	13
14	1884 Additions			1984	31,009	847	20	1,550	703	26,148	14
15	1985 Additions			1985	106,261	5,377	20	5,313	(64)	89,439	15
16	1986 Additions			1986	141,506	5,036	20	7,075	2,039	134,637	16
17	1987 Additions			1987	143,424	9,215	15	9,562	347	123,136	17
18	1988 Additions			1988	69,882	3,017	20	3,494	477	39,941	18
19	1989 Additions			1989	37,676	2,380	15	2,512	132	26,897	19
20	1990 Additions			1990	29,117	1,287	20	1,456	169	13,380	20
21	1991 Additions			1991	175,965	10,895	15	11,731	836	112,497	21
22	1992 Additions			1992	232,540	15,334	15	15,503	169	130,302	22
23	1993 Additions			1993	43,687	3,091	15	2,912	(179)	27,201	23
24	1994 Additions			1994	115,370	7,700	15	7,691	(9)	53,283	24
25	1995 Additions			1995	68,274	4,620	15	4,552	(68)	35,893	25
26	1996 Additions			1996	82,777	5,378	15	5,518	140	31,338	26
27	Wall covering			1997	4,601	460	10	460	0	1,725	27
28	Overbed lights			1997	3,400	340	10	340		1,331	28
29	Flooring			1997	967	64	15	64	0	226	29
30	Energy System			1997	9,560	637	15	637	0	2,124	30
31	Pneumatic System repair			1997	1,356	136	10	136	(0)	497	31
32	Air handler coil			1997	810	81	10	81		270	32
33	Disposal installed			1997	1,815	363	5	363		1,089	33
34	Fish pond			1997	9,455	630	15	630	0	2,206	34
35	Underground wiring			1997	1,524	102	15	102	(0)	398	35
36	TOTAL (lines 4 thru 35)				$ 3,383,368	$ 115,018		$ 119,711	$ 4,693	$ 2,329,995	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Compressor			1997	4,006	572	7	572	0	1,860	9
10	Bed lights			1998	3,524	352	10	352	0	998	10
11	Parts for call system			1998	450	45	10	45		90	11
12	Fish pond			1998	2,629	175	15	175	0	438	12
13	Garage door			1998	1,110	74	15	74		197	13
14	Door alarm equipment			1998	596	60	10	60	(0)	159	14
15	Fire eye controls			1998	1,110	74	15	74		197	15
16	Fire eye controls			1998	545	36	15	36		91	16
17	Chiller improvements			1998	1,503	100	15	100	0	242	17
18	Air conditioner			1998	5,217	348	15	348	(0)	725	18
19	Oil pump for compressor			1998	676	45	15	45	0	94	19
20	New pumps			1998	1,298	87	15	87	(0)	173	20
21	Boiler improvements			1998	3,195	213	15	213		426	21
22	Parking logs			1997	340	23	15	23	(0)	66	22
23	Boiler repairs			1998	475	32	15	32	(0)	84	23
24	Install fire eye			1998	182	12	15	12	0	32	24
25	Hot water storage tank			1998	11,904	595	20	595	0	1,339	25
26	Plumbing upgrades			1998	4,286	214	20	214	0	464	26
27	Compressor improvement			1998	1,333	89	15	89	(0)	193	27
28	Coil replacement			1998	1,048	70	15	70	(0)	151	28
29	Laundry room ventilation			1999	3,246	308	15	216	(92)	471	29
30	Steam generated tanks			1999	13,865	1,317	15	924	(393)	2,010	30
31	Pump			1999	924	92	10	92	0	92	31
32	Air conditioner			1999	2,476	248	10	248	(0)	248	32
33	Freezer compressor			2000	2,321	193	10	232	39	193	33
34	Air conditioner			2000	2,810	70	10	281	211	70	34
35	Exhaust Fan			2000	1,500	13	10	150	137	13	35
36	TOTAL (lines 4 thru 35)				$ 72,569	$ 5,457		$ 5,360	$ (97)	$ 11,116	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Hot water heater			2000	13,865	1,387	10	1,387	(1)	1,387	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 13,865	$ 1,387		$ 1,387	$ (1)	$ 1,387	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 483,144	$ 42,049	$ 40,262	$ (1,787)	12	$ 332,118	37
38	Current Year Purchases	7,851	279	523	244	15	279	38
39	Fully Depreciated Assets	116,627					116,627	39
40								40
41	TOTALS	$ 607,622	$ 42,328	$ 40,785	$ (1,543)		$ 449,024	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42		Van	1992	$ 38,295	$	$	$	5	$ 38,295	42
43		Ford Escort Wagon	1993	10,827				5	10,827	43
44		95 Ford Truck	1995	17,024	1,419	1,419		5	17,024	44
45										45
46	TOTALS			$ 66,146	$ 1,419	$ 1,419	$		$ 66,146	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,300,170	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 165,609	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 168,662	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,052	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,857,668	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 876	$	$ 876
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 876	$	$ 876
10	SUM OF line 9, col. 1 and 2 (e)	$ 876			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39		61,748			8,238		69,986	12
13	Other (specify):									13
14	TOTAL			$ 61,748		$	$ 8,238		$ 69,986	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/1/99 **Ending:** 11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,005	$	1
2	Cash-Patient Deposits	3,086		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,104,477		3
4	Supply Inventory (priced at cost)	34,378		4
5	Short-Term Investments	443,971		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,600,917	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	156,600		13
14	Buildings, at Historical Cost	3,469,803		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	673,768		16
17	Accumulated Depreciation (book methods)	(2,857,672)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,219		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,452,718	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,053,635	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 167,873	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,086		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,188		30
31	Accrued Taxes Payable (excluding real estate taxes)	38		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to other funds	96,298		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 452,483	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Patient Memorials	10,219		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,219	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 462,702	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,590,933	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,053,635	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,670,145	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,670,145	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,079,211)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,079,212)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,590,933	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,863,924	1
2	Discounts and Allowances for all Levels	(6,263)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,857,661	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	22,926	12
13	Barber and Beauty Care	28,314	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,240	23
	D. Non-Operating Revenue		
24	Contributions	4,328	24
25	Interest and Other Investment Income***	47,278	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,606	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	11,268	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,268	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,971,775	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,635,752	31
32	Health Care	3,692,618	32
33	General Administration	1,359,299	33
	B. Capital Expense		
34	Ownership	165,608	34
	C. Ancillary Expense		
35	Special Cost Centers	84,081	35
36	Provider Participation Fee	113,628	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,050,986	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,079,211)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,079,211)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,484	1,874	$ 50,258	$ 26.82	1
2	Assistant Director of Nursing	1,629	1,869	45,408	24.30	2
3	Registered Nurses	15,971	17,137	328,183	19.15	3
4	Licensed Practical Nurses	47,312	52,375	761,358	14.54	4
5	Nurse Aides & Orderlies	129,805	139,707	1,398,305	10.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,983	12,383	111,686	9.02	10
11	Social Service Workers	7,337	8,049	90,850	11.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,912	41,800	347,644	8.32	15
16	Dishwashers					16
17	Maintenance Workers	8,075	8,379	104,320	12.45	17
18	Housekeepers	26,497	29,269	239,488	8.18	18
19	Laundry	21,759	25,037	210,879	8.42	19
20	Administrator	2,080	2,080	63,054	30.31	20
21	Assistant Administrator					21
22	Other Administrative	16,347	17,918	179,215	10.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty shop	3,794	4,174	32,221	7.72	33
34	TOTAL (lines 1 - 33)	332,985	362,051	$ 3,962,869 *	$ 10.95	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	221	$ 6,435	line 1, col 3	35
36	Medical Director	15	3,600	line 9, col 3	36
37	Medical Records Consultant	25	1,830	line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	44	1,800	line 10, col 3	39
40	Physical Therapy Consultant	126	6,090	line 10a, col3	40
41	Occupational Therapy Consultant	103	4,726	line 10a, col3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	13	590	line 10a, col3	43
44	Activity Consultant	21	508	line 11, col 3	44
45	Social Service Consultant	61	1,445	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	629	$ 27,024		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	Ln 10, Col 1	50
51	Licensed Practical Nurses			Ln 10, Col 1	51
52	Nurse Aides	22,973	342,733	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)	22,973	$ 342,733		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ben Perkins	Administrator	None	$ 63,054
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,054

B. Administrative - Other

Description	Amount
Committee per diem	$ 5,005
TOTAL (agree to Schedule V, line 17, col. 3)	$ 5,005
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Blucker, Kneer & Assoc.	Audit	$ 5,000
Robert Rein	Accountant	8,726
State's Attorney Appellate		
Prosecutor	Legal	1,960
Claudon, Lloyd, Barnhart, Beal	Legal	16
James Skinner		303
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,005

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 146,476
Unemployment Compensation Insurance	26,172
FICA Taxes	303,979
Employee Health Insurance	230,706
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	198,328
Employee physicals	5,991
Sign on bonus	6,625
Employee incentives	108
Longevity	72,623
TOTAL (agree to Schedule V, line 22, col.8)	$ 991,008

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	876
(Indicate # of checks performed 73)	
Dues & Subscriptions	9,768
Advertising PR & Other	27,777
Contingencies	2,990
Less: Public Relations Expense	( )
Non-allowable advertising	(27,777)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,634

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,444
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,444

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/99 Ending: 11/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA, $7907**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **79,353** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **113,628**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Blucker, Kneer, & Assoc., LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.